STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF CARMEL LLC	301 EXECUTIVE DR CARMEL, IN 46032

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R000000	This visit was for a State Resdiential Licensure Survey. Survey dates: April 4, 5, and 11, 2013. Survey team: Michelle Hosteter, RN-TC Janet Stanton, RN Gloria Bond, RN Facility number: 010416 Provider number : 010416 AIM number: N/A Census bed type: Residential : 59 Total: 59 Census payor type: Other: 59 Total : 59 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on April 15, 2013.	R000000	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000026	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation and interview, the facility failed to have the Residents Rights posted in the facility. This deficit practice had the potential to affect 59 of 59 residents residing at the facility. Findings include: In an observation on 4/4/13 at 1 p.m., there was no resident rights posted in the survey book or in any of the hallways on either the first or second floor.	R000026	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating	04/27/2013

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	In an interview with the Health and Wellness Director on 4/4/13 at 1:30 p.m., she indicated the only Resident Rights they had posted were the ones displayed per the Ombudsmen instructions. She indicated they gave the residents a copy of the resident rights upon admission.		factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?~The Executive Director relocated the Residents Rights to an area of the facility whereby it is readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility. The Executive Director relocated the Residents Rights on 4/5/13, during the survey and pointed out the location to the surveyor during the annual survey.How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?~To ensure that all residents, resident's family and visitors have immediate access to the Residents Rights, they will be readily available amd accessible to the residents, resident's family and visitors, in a publically accessible area within the facility.What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?~The Exectutive Director will ensure that the Residents Rights are maintained in an area of	

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			the facility whereby they are readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Residents Rights will consistently be maintained in an area of the facility whereby they are readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility.By what date will these systemic changes be implemented?4/5/13	

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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to consult the resident's physician after an ER (emergency room) visit for 1 of 1 resident reviewed for physician notification in the sample of 7. (Resident #30) Findings include: The record of Resident #30 was reviewed on 4/4/2013 at 2:30 p.m. Diagnoses included but were not limited to, dementia with behavior disturbances, diabetes type II, hypothyroidism (low thyroid). The nurses's notes dated 2/21/2013 at 12:15 a.m., indicated, "Rec'd (received) report from ... ER (emergency room) stating resident will be returning to the facility. Papers will be sent with resident and to follow up..." with resident's physician. ER	R000036	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?~The Health & Wellness Director has conducted	04/27/2013

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	"Patient discharge disposition form" indicated, "...diagnoses of abdominal pain, blood in stool,...Follow up with [Resident's physician] for re-evaluation and further testing...." The record lacked documentation of Resident #30's physician being consulted after the ER visit for blood in stool. In an interview with HWD (Health Wellness Director) on 4/11/2013 at 1:20 p.m., she indicated after searching she was not able to find documentation the Resident's physician was notified regarding the Resident's condition after the ER visit on 2/21/2013.		a nursing in-service with nurses, regarding physician notification after residents return from the emergency room. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ~The Health & Wellness Director and/or Designee will conduct a weekly audit, for thirty days, of residents sent out to the emergency room, utilizing the Physician Notification Quality Assessment Tool to ensure that the facility is following up and consulting the physician after the resident's return to the facility following an emergency room visit. Nurses found to be non-compliant with physician notifications/consults will be properly disciplined.What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?~The Health & Wellness Director and/or Designee will conduct a weekly audit, for thirty days, of residents sent out to the emergency room, utilizing the Physician Notification Quality Assessment Tool to ensure that the facility is following up and consulting the physician after the resident's return to the facility following an emergency room visit. Nurses found to be non-compliant with physician notifications/consults will be	

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			properly disciplined.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?~The Health & Wellness Director will submit audits to the Executive Director of the month in review. In the event of nursing non-compliance, the Executive Director and the Health & Wellness Director will be responsible for corrective actions with the appropriate nursing associate.By what date will these systemic changes be implemented?`4/27/2013	

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R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any			

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	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation and interview, the facility did not have a notice posted regarding the survey results being available, the survey book was not in a readily accessible area, and the most recent survey results were not posted. This deficit practice had the potential to affect 59 of 59 residents residing in the facility. Findings include: In an observation on 4/4/13 at 1:30 p.m., there was no notice posted regarding where the survey results were located. The survey book was not readily accessible. In an interview with the Health and Wellness Director (HWD) on 4/4/13 at 1:40 p.m., she indicated the survey book was kept behind the receptionists desk. She also indicated the sign posted indicated, "ask receptionist for survey results." The HWD and receptionist had to search and ask others where the	R000090	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?~The Executive Director relocated the Survey Binder, containing the the most recent survey results, to an area of the facility whereby it is readily available and accessible to the	04/27/2013

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	survey book was presently located. The most recent survey posted in the survey book was dated 2011. There were no complaints or the most recent annual survey from 2012 posted in the survey book.		residents, resident's family and visitors, in a publically accessible area within the facility. The Executive Director relocated the Survey Binder on 4/5/13, during the survey and pointed out the location to the surveyor during the annual survey.How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?~The Executive Director will ensure that the Survey Binder, containing the the most recent survey results, be maintained in an area of the facility whereby it is readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility. What measures will be put in place or what systemic changes will the facility make to ensure the alledged deficient practice does not recur?~The Executive Director will ensure that the Survey Binder, containing the the most recent survey results, be maintained in an area of the facility whereby it is readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?~The Survey Binder, containing the most	

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			recent survey results will be consistently maintained in an area of the facility whereby it is readily available and accessible to the residents, resident's family and visitors, in a publically accessible area within the facility. By what date will these systemic changes be implemented?~The Executive Director relocated the Survey Binder on 4/5/13, during the survey and pointed out the location to the surveyor during the annual survey.	

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R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to keep living areas free from hazards for residents with confusion for 18 of 59 residents living in the facility. (Resident #14, Resident #21, and Resident #22) Findings include: During the initial tour with LPN #1 on 4/4/13 at 10:45 a.m., she indicated Resident #14 had behaviors of hitting and is verbally aggressive with staff. In an observation on 4/4/13 at 11 a.m., Resident #21 and Resident #22	R000148	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care	04/27/2013

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	who were married, were walking in the hallway. Resident #22 was pulling on the arm of Resident #21 to walk with him. Resident #21 was having noticeable difficulty in her gait and the staff intervened to prevent her from falling. Resident #22 became agitated and would not let go of the arm of Resident #21. During environmental rounds on 4/4/13 at 2:00 p.m., a basket of silverware with the tines of the forks, the blades of the knives sticking up out of the basket was observed on the Trains and Travels as well as the Collegiate Sports units. The basket of silverware on the Trains and Travel unit was within reach of Resident #21 and Resident #22. The basket on the Collegiate Sports unit is where Resident #14 resided. There were no staff visible in the areas at this time. During the environmental tour with the Maintenance Manager and the Executive Director on 4/5/13 at 10:10 a.m., the baskets of silverware were still within reach of the residents on the Trains and Travels and the Collegiate Sports units and there were no staff in the area at this time. In an interview with the Executive Director on 4/4/13 at 10:12 a.m., she		services and will continue to make changes and improvements to satisfy that objective.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?~The facility will conduct an in-service for the certified nursing assistants regarding resident safety and the importance of not leaving silverware baskets unattended in the facility neighborhoods. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?~The Resident Care Coordinator and/or Designee will conduct a daily audit, for thirty days, of facility neighborhoods within the community, on varying shifts, to ensure that the facility certified nursing assistants are following proper safety precautions and not leaving the silverware baskets unattended. Certified nursing assistants found to be non-compliant with safety precautions will be properly disciplined.What measures will be put in place or what systemic changes will the facility make to ensure the alledged deficient practice does not recur?~The Resident Care Coordinator and/or Designee will conduct a dailly audit, for thirty days, of facility neighborhoods within the	

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	indicated the silverware should not be out like that and the staff are to put it away if it is clean. A document titled Daily Assignment Sheet provided by the Executive Director on 4/5/13 at 10:45 a.m. indicated for both the Collegiate Sports and Trains and Travels units the staff are to,"...Wash dishes put away when done don't leave unattended...."		community, on varying shifts, to ensure that the facility certified nursing assistants are following proper safety precautions and not leaving the silverware baskets unattended, utilizing the Safety Assessment Tool. Certified nursing assistants found to be non-compliant with safety precautions will be properly disciplined.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Resident Coordinator will submit audits to the Executive Director for the timeframe. In the event of non-compliance, the Executive Director, the Health & Wellness Director and the Resident Care Coordinator will be responsible for corrective actions with the appropriate certified nursing assistant associate.By what date will these systemic changes be implemented?~4/27/2013	

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R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview and record review, the facility failed to address the current needs of 2 of 7 residents reviewed for updated care and service plans. (Residents #11 and #54) Findings include:	R000217	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual survey completed on 4-11-13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or	04/27/2013

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		A. BUILDING 00 B. WING	04/11/2013

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	1. In an interview during the initial tour on 4/4/13 at 10:45 A.M., LPN # 1 indicated Resident #11 was receiving Hospice services contracted through an outside agency. The clinical record was reviewed on 4/4/13 at 12:15 P.M. Diagnoses included, but were not limited to, Lewy body dementia with delusions, bipolar disorder, bilateral retinal detachment, severe arthritis with kyphosis (curvature of the spine), and spinal stenosis with degenerative disc disease of the cervical spine. An Contract form from the Hospice agency, dated 12/10/12, indicated the resident was admitted to that agency's services on that date. The April, 2013 physician order recap (recapitulation) sheet listed orders that included, but were not limited to, the following: 12/12/11--Bed alarms ["Discontinue 3/1/13"]; and Hoyer (mechanical) lift with assistance of 2 (staff). On 4/4/13 at 12:10 P.M., the resident was observed sitting in a high-back wheelchair at a table in his unit's dining room area. A CNA was sitting next to the resident, feeding him his		any related sanction and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?~The Health & Wellness Director updated the Personal Service Plans for resident #11 and resident #54 on 4/5/13, during the annual survey and submitted the updated Personal Service Plans to the surveyor. The updated Personal Service Plans will be maintained in resident #11 and resident #54's medical chart, within the facility and followed by the facility. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?~The Health & Wellness Director will meet weekly with the Resident Care Coordinator and bi-weekly with the therapy team and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness	

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	lunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: "... Bilateral retinal detachments...Legally blind in right eye...severe arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosis...Resident is on [name of Hospice agency]...Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staff...Since assessment, the resident is now able to stand by himself and is easily directed to the bathroom by associates...He does walk with his head down to where his chin can touch his neck...He has been ambulatory a few days prior to move in and is now ambulating around the community by himself...." This Service Plan also listed the services to be provided to the		Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ~The Health & Wellness Director will meet weekly with the Resident Care Coordinator and bi-weekly with the therapy team and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will work with the nursing team to ensure that the most recent Personal Service Plans are in the resident's medical cart and being followed by the nursing team.By what date will these systemic changes be implemented? ~4/27/2013	

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	resident by the facility. The services included, but were not limited to, the following: "Provide direct physical assistance while eating (e.g. prompts such as demonstration and hand under hand, redirection to sit) as needed; ...Resident is able to perform the following tasks with physical assistance as needed: putting on/taking off clothing, fastening/unfastening clothing, putting on/taking off socks/shoes; ...Resident is able to perform the following showering tasks with physical assistance as needed: shampooing hair, washing upper body, washing lower body; ...Resident needs help in the bathroom: assist with pulling pants up and down, assist with handling of toilet paper and wiping from front to back...;Resident is incontinent of bladder; Resident is incontinent of bowel; ...Encourage resident to use handrails in bathroom, encourage resident to lock wheelchair if applicable; ...Resident uses bed alarm...." The Service Plan did not address the changes and decline in the resident's physical condition--no longer able to ambulate or do other ADL (Activity of Daily Living) care, use of a mechanical lift for transfers, or need to be fed by facility or Hospice staff.			

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	There was no indication what services the hospice agency was providing, only that the resident was "on" hospice. The Service Plan was not updated when the bed alarms were discontinued. In an interview on 4/5/13 at 10:40 A.M., the Health Wellness Director indicated she was the one who wrote the Service Plans and had done so since about the second week in November, 2012. She indicated she did updates as required, including when there was a significant change. She indicated she would need to check in some other files to determine if this resident's Service Plan had been updated to reflect his current status and needs. On 4/11/13 at 11:45 A.M., the Health Wellness Director provided a Service Plan that had been completed on 4/5/13 at 2:57 P.M. She indicated she had not found any other Service Plan prior to this one, or after the one that had been completed on 2/12/13. 2. The record review for Resident #54 was completed on 4/4/13 at 11:30 a.m. Diagnoses included, but were not limited to, depression, dementia and a history of			

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	subarachnoid hemorrhage. In the clinical record the most recent service plan for Resident #54 was dated 11/28/12. The service plan indicated regarding nutrition for the resident, "...pureed foods, be alert to coughing and choking while eating. Provide direct staff attention and assistance while eating. Allow for extended meal time. Be alert to weight loss...." The nursing notes indicated on 1/9/13 through 1/12/13, the resident had episodes of vomiting which they attributed to the flu. The nurses notes indicated on 1/16/13 2:40 p.m., "...Res [resident] had problems [sign for with] swallowing liquids order for speech therapy to eval [evaluate]...." The physician's orders indicated on 1/21/13 the resident was to be started on nectar thickened liquids. In an interview with the Health and Wellness Director (HWD) on 4/11/13 at 9 a.m., she indicated they updated the service plan. She also indicated the most recent service plan the resident had was dated 11/28/12. The service plan provided by the HWD was dated 4/5/13. The service plan indicated the resident was on nectar			

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	thickened liquids.			